CE Registration Form

Contact Information-*Please complete all fields*.

- First Name: ________________________________ MI: _________________________
- Last Name: ____
- Business Affiliation: ____
- Degree: ____
- Office Address: ____
- City: ____
- State: ________________________________ Zip: _____________________________
- Office Phone: ____
- Fax Number: ____
- Email Address: ____

Course Information

- Name of Course: ____
- Location of Course (*if offered at multiple locations*): ______________________________
- Dates/Times (*if a date and time selection is necessary*): ___________________________

Payment Information—*Please complete all fields*.

- Payment Method: _____ VISA _____ MasterCard _____ Check payable to UKCD CE
  - Name on Card: ____
  - Card Number: ____________________________ Expiration Date: _____________
  - Signature: ____
  - Billing Address for Card: ____

    (Street, City, State, Zip)

Form Submission Information

- **Fax** completed form to: (859) 257–0486
- **Mail** payment and completed form to: University of Kentucky, College of Dentistry Continuing Education, 800 Rose Street, Attn. Elaine Stafford, Dental Science Bldg., Lexington, KY 40536-0297
- **Call** (859) 323–8155 or (859) 323–8187 to register